WT: _____ HT: _____ BLOOD PRESSURE: _____ PULSE: _____ LOCATION: L or R

NAME: _____ AGE: _____ DATE OF BIRTH: _____

REASON FOR VISIT:	FIRST DAY OF LAST PERIOD:	FREQUENCY:	DURATION:
_____	_____	_____	_____

ALLERGIES TO MEDICATION? REACTION?

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

PAST/CURRENT MEDICAL HISTORY

- ❑ ASTHMA
- ❑ MIGRAINES
- ❑ ANXIETY
- ❑ DEPRESSION
- ❑ THYROID: HYPO or HYPER
- ❑ OTHER: _____

_____

PROCEDURES/SURGERY:

_____

_____

_____

_____

FAMILY HISTORY:

BREAST CANCER:_____
UTERINE CANCER:_____
OVARIAN CANCER:_____
COLON CANCER: _____
ANY TYPE OF CANCER:_____
HIGH BLOOD PRESSURE:_____
DIABETES:_____
HEART DISEASE:_____

SOCIAL HISTORY:

OCCUPATION:_____
MARITAL STATUS:_____
SMOKING:_____
DRINKING:_____
DRUGS:_____

OB HISTORY:	#	DELIVERY DATE	GESTATIONAL AGE	SEX	WEIGHT	DELIVERY TYPE
Total # of pregnancies:						
Live Births:						
Miscarriage:						
Abortion:		❑ D&C		❑ MEDICAL		
Ectopic:						

LAST PAP: _____ LAST MAMMO: _____ LAST BONE DENSITY SCAN: _____

LAST COLONOSCOPY: _____